DEPARTMENT	OF HEALTH AN	D HUMAN S	SERVICES
CENTERS FOR	MEDICARE & N	MEDICAID S	SERVICES

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
		155003	B. WIN			07/15/2	011
			B. WIN		ADDRESS CITY STATE ZIR CODE		
NAME OF F	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
N4400NI	UEALTH OADE OF	NITED	900 PROVIDENT DR				
MASON HEALTH CARE CENTER				WARSAW, IN46580			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	-	DATE
F0000							
	This visit was for	r the Investigation of	F0	000	July 31, 2011 Mrs. Kim		İ
	Complaint IN000				Rhoades, DirectorLong Term	ı	
	Complaint 11 too	0,75255.			Care DivisionIndiana State		
	C 1 : / D100/	202225 G 1 4 4 4 1			Department of Health2 N.		
	•	093235: Substantiated,			Meridian StreetIndianapolis,		
		ficiencies related to the			46204 Re: Mason Health Ca		
	allegations cited	at F 225 and F 226.			Provider Number: 155003St		
					Dates: July 14-July 15, 2011 Mrs. Rhoades: Enclosed ple		
	Survey dates: 7/1	14-15/11			find our completed plan of	asc	
					correction responding to the		
	Essili6	000002			survey conducted at our facil	litv	
	Facility number:				ending 7/15/11 and the 2567	-	
	Provider number				dated 7/15/11. All POC		
	AIM number: 10	0290600			measures have been or will l	be	
					fully implemented by July 31	,	
	Survey team:				2011. Mason Health Care		
	Ellen Ruppel, Ri	N TC			respectfully asks that our pla		
	Honey Kuhn, RN				correction be considered to		
	Honey Kum, Kr	•			as our allegation of complian		
					for the cited tags F225 and F as of that date. I ask that the		
	Census bed type:				tags be cleared through the	Citcu	
	SNF: 3				desk/paper review process.	As	
	SNF/NF: 87				noted on the plan of correction		
	Total: 90				the POC should not be cons	-	
					as an admission as to the va	lidity	
	Census payor typ	ne.			of any of the citations. Pleas		
					assured, however, that altho		
	Medicare: 20				the facility disagrees with the		
	Medicaid: 55				citations, we have considere		
	Other: 15				survey concerns very serious	sıy	
	Total: 90				and have undertaken the necessary measures to ensu	ıro	
					findings of compliance as of		
	Sample: 4				31, 2011. Quality monitoring		
	Sumple. T				in-services will be provided of		
		1 9			continuing basis to assure a		
		es also reflect state			ongoing understanding and		
	findings cited in	accordance with 410 IAC			implementation of policies ar	nd	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000003

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAIN	OF CORRECTION	155003	A. BUILDING	00	COMPLETED 07/15/2011
		100000	B. WING	ADDRESS, CITY, STATE, ZIP CODE	0771072011
NAME OF P	PROVIDER OR SUPPLIER		l l	ROVIDENT DR	
	HEALTH CARE CEI		WARSA	AW, IN46580	
	SUMMARY STATEMENT OF DEFICIENCIES (FACH DEFICIENCY MUST BE PERCEDED BY FULL)		1	PROVIDER'S PLAN OF CORRECTION	
	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		1	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) ompleted 7/18/11	ID PREFIX TAG	Ι	ued me rns n n and
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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		155003	B. WING 07/15/2			011	
			B. WING		DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER						
MACON		NTED			OVIDENT DR		
IVIASON	HEALTH CARE CEI	NIER		WARSA	W, IN46580		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES				PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		F	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	ļ	TAG	DEFICIENCY)		DATE
F0225	,	ot employ individuals who					
SS=E	-	guilty of abusing, neglecting,					
	•	dents by a court of law; or					
		g entered into the State					
		/ concerning abuse, neglect,					
		sidents or misappropriation and report any knowledge it					
		a court of law against an					
		would indicate unfitness for					
		aide or other facility staff to					
	the State nurse aide registry or licensing						
authorities.							
The facility must ensure that all alleged							
		g mistreatment, neglect, or					
		njuries of unknown source					
		ion of resident property are					
	•	ely to the administrator of					
		other officials in accordance ough established procedures					
		tate survey and certification					
	agency).	tate survey and certification					
	ageney).						
	The facility must h	ave evidence that all					
		are thoroughly investigated,					
	_	further potential abuse while					
	the investigation is	s in progress.					
		nvestigations must be					
		ministrator or his designated					
		d to other officials in	1				
accordance with State law (including to the		· · · · · · · · · · · · · · · · · · ·					
		certification agency) within 5 e incident, and if the alleged					
		lappropriate corrective					
	action must be tak		1				
		review and interviews,	F02	25	1.) Facility Disclaimer 2.)		07/31/2011
		to ensure all reported	102	1.0223	Credible Allegation of Substa		J//JI/2011
	· ·				Compliance This Plan of		
		use and neglect from staff			Correction (POC) is prepared an		
		ivestigated and reported			executed because it is requir		
	to the state agence	ey as regulations and the			by the provisions of State and	d	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIIII	LDING	00	COMPLETED	
		155003	B. WIN			07/15/2	011
		II.	P. (12)		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹		1	OVIDENT DR		
MASON HEALTH CARE CENTER			1	AW, IN46580			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	facility policy in	dicated. This deficiency			Federal Law, and not because		
	potentially relate	ed to 23 of 27 residents			Mason Health Care agrees w	vitn	
	on 1 of 4 halls in	a census of 90 in the			the allegations contained there-in. Mason Health Care	_	
	facility. (The 30	00 hall)			maintains that each deficience		
		,			does not jeopardize the heal	•	
	Findings include	•			and safety of the residents, r		
	1 manigs merade	··			it of such character as to limi		
	D	ii4h-4h-			capability to render adequate	•	
	During an interv				care. Please let these POC	4:	
		nd Corporate Nurse, on			responses serve as the facili Credible Allegation of Compl		
		a.m., they indicated an			7/31/11. We ask that the cite		
		ied Nursing Assistant			tags be cleared through the	-	
	(CNA) #20 had	written the corporate hot			desk/paper review process. I	F225	
	line a letter indic	cating the Restorative			Investigate/Report		
	Nurse (LPN#8)	had told an aide to "force			Allegations/IndividualsThis p	lan of	
	feed" a depender	nt resident who later died.			correction is prepared and executed because the provis	ione	
	The allegations a	also included lack of care			of State and Federal law req		
	by aides, leaving	g resident soiled and			and not because Mason Hea		
		for the mouth. Included			Care agrees with the allegati	ons	
	1	were concerns regarding			made in the cited deficiencie		
	_	er holding a resident so			The facility maintains that the	9	
		administer medication and			alleged deficiencies do not individually or collectively		
		aff member doing nursing			jeopardize the health and sa	fetv	
		an member doing nursing			of the residents, nor are they		
	care.				such character so as to limit		
					capability to render adequate		
		cility census form, dated			care. It is facility practice to r		
	7/14/2011, and p	•			employ individuals who have been found guilty of abusing		
	Administrator, o	n 7/14/11 at 9:45 a.m.,			neglecting, or mistreating	,	
	indicated the 300	hall of the facility			residents by a court of law, o	r l	
	housed 27 of the	total 90 residents. 23 of			have had a finding entered ir		
	the 27 were desi	gnated as cognitively			State nurse aide registry		
	impaired.	-			concerning abuse, neglect,		
	^				mistreatment of residents or	oortv:	
	When queried o	n 7/14/11 at 11:00 a.m.,			misappropriation of their prop and report any knowledge it	-	
	1 -	e allegations had been			of actions by a court of law		
	i about the date th	e anegations nad been			or actions by a court or law		

000003

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155003 07/15/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 900 PROVIDENT DR MASON HEALTH CARE CENTER WARSAW, IN46580 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE received by the facility, the Administrator against an employee, which would indicate unfitness for and Corporate Nurse indicated "sometime service as a nurse aide or other last week." The specific date the facility staff to the State nurse corporate hot line was contacted by the aide registry or licensing authorities. It is facility practice to former employee and facility was notified ensure that all alleged violations were not disclosed by the Administrator or involving mistreatment, neglect, Corporate Nurse. The exact date the or abuse including injuries of investigation was begun was not unknown source and indicated misappropriation of resident property are reported immediately to the administrator of the facility When queried about reporting the and to other officials in allegations to the State Survey Agency, accordance with State law the Administrator indicated no report had through established procedures (including to the State survey and been sent. She indicated the investigation certification agency). It is facility was in process and she had started the practice to ensure that all alleged reporting process, but had not sent it to violations are thoroughly investigated, and to prevent the State Survey Agency as of 7/14/11. further potential abuse while the investigation is in progress. It is Review of an employee interview form, facility practice to ensure that the dated 7/6/11, and provided by the results of all investigations are Corporate Nurse, on 7/15/11 at 9:00 a.m., reported to the administrator or his designated representative and the form indicated the interview had been to other officials in accordance conducted on 7/6/11. This indicated the with State law (including to the facility was aware of the allegations a State survey and certification week prior to the survey visit. agency) with 5 working days of the incident, and if the alleged violation is verified appropriate Review of the facility policy regarding corrective action must be abuse reporting, provided by the taken. We ask that this cited tag Administrator on 7/14/11 at 10:00 a.m., be cleared through the desk/paper review process. 1. indicated the policy had been in effect Cited Residents: Corrective since 10/2005. The policy indicated, in action cannot be taken due to the part: "8. the facility will ensure that all alleged deficiency occurred in the allegations of mistreatment, neglect or past. Investigation by the facility did not substantiate the alleged abuse, including injuries of unknown

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
		155003	B. WING			07/15/2011	
			B. WINC		DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				OVIDENT DR		
MASON HEALTH CARE CENTER		NTER			W, IN46580		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES				PROVIDER'S PLAN OF CORRECTION	ECTION (X5)	
PREFIX	, i	CY MUST BE PERCEDED BY FULL]	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	source, are repor	ted immediately to the			violations. Investigation by the	ne	
	Administrator or	other officials in			survey team on 7/14/11 and	. ا	
	accordance with	state law though			7/15/11 did not substantiate t alleged violations. 2. Other	ne	
	established proce	_			Residents: All residents have	e the	
	•	all notify ISDH in			potential to be effected by the		
		ISDH Guidelines." This			alleged deficiency. 3.		
	had not been don				Recurrence: All staff will be		
	nad not been don	le.			reinserviced on Abuse and		
					Neglect reporting. Managem		
	_	relates to Complaint			staff and licensed nursing sta will be reinserviced on Abuse		
	IN00093235				Neglect Investigation. 4.	anu	
					Monitoring: The		
	3.1-28(a)				Administrator/Director of Nur	sing,	
	3.1-28(c)				or designee, will monitor		
	3.1-28(d)				employees and residents 5x/	wk x	
	3.1-28(e)				6wk, then 3x/wk x 3wk, then		
	3.1 20(c)				weekly to ensure		
					resident/employee concerns		
					investigated/reported per pol The Administrator/Director of		
					Nursing, or designee, will rep		
					findings to the QA Committee		
					monthly x 6mon and quarterl		
					thereafter.5. Date: 7/31/11.		
F0226	,	evelop and implement					
SS=E	•	d procedures that prohibit					
	, ,	lect, and abuse of residents					
		ion of resident property.	F06	,,,	1 \ Facility Disclaimer 2 \		07/21/2011
		review and interviews,	F02	226	 Facility Disclaimer 2.) Credible Allegation of Substa 	ıntial	07/31/2011
	_	to report allegations of			Compliance This Plan of	iiidi	
	_	t from staff members to			Correction (POC) is prepared	d and	
	the state agency	as regulations and the			executed because it is requir		
	facility policy in	dicated. This deficiency			by the provisions of State and		
	potentially relate	d to 23 of 27 residents			Federal Law, and not becaus		
		a census of 90 in the			Mason Health Care agrees we the allegations contained	/ith	
	facility. (The 30				the allegations contained there-in. Mason Health Care	,	
		- '			maintains that each deficience		
					does not jeopardize the healt		
					<u> </u>		

000003

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155003 07/15/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 900 PROVIDENT DR MASON HEALTH CARE CENTER WARSAW, IN46580 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Findings include: and safety of the residents, nor is it of such character as to limit our capability to render adequate During an interview with the care. Please let these POC Administrator and Corporate Nurse, on responses serve as the facilities Credible Allegation of Compliance 7/14/11 at 11:00 a.m., they indicated an 7/31/11. We ask that the cited employee Certified Nursing Assistant tags be cleared through the (CNA) #20 had written the corporate hot desk/paper review process. F226 line a letter indicating the Restorative Develop/Implement Nurse (LPN#8) had told an aide to "force Abuse/Neglect, etc PoliciesThis plan of correction is prepared and feed" a dependent resident who later died. executed because the provisions The allegations also included lack of care of State and Federal law require it by aides, leaving resident soiled and and not because Mason Health without hygiene for the mouth. Included Care agrees with the allegations made in the cited deficiencies. in the allegation were concerns regarding The facility maintains that the the Social Worker holding a resident so alleged deficiencies do not the nurse could administer medication and individually or collectively an unlicensed staff member doing nursing jeopardize the health and safety of the residents, nor are they of care. such character so as to limit our capability to render adequate Review of the facility census form, dated care. It is facility practice to 7/14/2011, and provided by the develop and implement written policies and procedures that Administrator, on 7/14/11 at 9:45 a.m., prohibit mistreatment, neglect, indicated the 300 hall of the facility and abuse of residents and housed 27 of the total 90 residents. 23 of misappropriation of resident the 27 were designated as cognitively property. We ask that this cited tag be cleared through the impaired. desk/paper review process. 1. Cited Residents: Corrective When queried, on 7/14/11 at 11:00 a.m., action cannot be taken due to the about the date the allegations had been alleged deficiency occurred in the past. Investigation by the facility received by the facility, the Administrator did not substantiate the alleged and Corporate Nurse indicated "sometime violations. Investigation by the last week." survey team on 7/14/11 and When queried about reporting the 7/15/11 did not substantiate the alleged violations. 2. Other allegations to the State Survey Agency, Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED		
		155003	B. WIN			07/15/2	011	
		l .	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIEF	8		1	OVIDENT DR			
MASON	HEALTH CARE CE	NTER		1	W, IN46580			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	the Administrato	or indicated no report had			Residents: All residents hav			
	been sent. She is	ndicated the investigation			potential to be effected by the	е		
	was in process a	nd she had started the			alleged deficiency. 3. Recurrence: All staff will be			
	_	s, but had not sent it to			reinserviced on Abuse and			
		Agency as of 7/14/11.			Neglect reporting. Managem	nent		
		rigency as of minimi.			staff and licensed nursing sta			
	Davious of an am	nlovoo intorvious form			will be reinserviced on Abuse	and		
		nployee interview form,			Neglect Investigation 4.			
		d provided by the			Monitoring: The			
		e, on 7/15/11 at 9:00 a.m.,			Administrator/Director of Nur or designee, will monitor	sing,		
		ed the interview had been			employees and residents 5x/	wk x		
	conducted on 7/6	5/11. This indicated the			6wk, then 3x/wk x 3wk, then	WICA		
	facility was awar	re of the allegations a			weekly to ensure			
	week prior to the	e survey visit.			resident/employee concerns			
					investigated/reported per pol The Administrator/Director of	-		
	Review of the fa	cility policy regarding						
	abuse reporting,			Nursing, or designee, will report				
		n 7/14/11 at 10:00 a.m.,			findings to the QA Committee monthly x 6mon and quarterly			
		-			thereafter. 5. Date: 7/31/11.	y		
	_	licy had been in effect						
		The policy indicated, in						
	1 ^	cility will ensure that all						
	1	istreatment, neglect or						
	abuse, including	injuries of unknown						
	source, are repor	ted immediately to the						
	Administrator or	other officials in						
	accordance with	state law though						
	established proce	· ·						
	_	nall notify ISDH in						
		ISDH Guidelines." This						
	had not been dor							
	nau not been dor	IC.						
	This end is	1.4.4.0						
	_	relates to Complaint						
	IN00093235							
	3.1-28(a)							

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

l	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155003	(X2) MULTIPLE CO A. BUILDING B. WING	00	li i	E SURVEY PLETED /2011
NAME OF PROVIDER OR SUPPLIER MASON HEALTH CARE CENTER			900 PR	ADDRESS, CITY, STATE, ZIP COVIDENT DR AW, IN46580	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE